Male Chronic Pelvic Pain Secondary to Traumatic Osteitis Pubis

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Introduction

Chronic pelvic pain (CPP) in females has a comparable prevalence to female chronic back pain. However, male CPP is less common with half the prevalence of female CPP.[1] Male CPP is overlooked and mistakenly attributed to prostatitis.[2] Misdiagnosis results in costly evaluations and ineffective treatments. We present a complex case of male CPP following traumatic injury attributed to osteitis pubis and treated with fluoroscopy-guided pubic symphysis steroid injection after failure of conservative and multidisciplinary therapies.

Case Presentation

This is a 41-year-old male with 17 years of intermittent CPP concerning for osteitis pubis secondary to a pubic fracture. His pain localized to the pubic region and was described as intermittent 6/10 pain on the visual analogue scale (VAS) that is sharp, burning, and aching. When present, pelvic pain interfered with activities of daily living (ADLs), although patient remained ambulatory without walk assist device. No reports of dysuria, urinary or bowel incontinence, or saddle anesthesia. Work-up performed by Urology included negative urinalysis, cystoscopy, and pelvic X-ray. Examination showed positive modified Trendelenburg test bilaterally and tenderness to palpation of the pubic symphysis and bilateral hip adductors. Failed therapies included: gabapentin, nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, pelvic floor physical therapy, massage, and temperature therapy. Given refractory pelvic pain concerning for osteitis pubis, patient received fluoroscopy-guided bilateral pubic symphysis joint injection with 1ml solution of 10mg dexamethasone and 2% methylparaben free lidocaine. The immediate pre- and post-operative subjective VAS scores improved from a 6/10 to a 4/10, and over 90% relief at 6 weeks follow-up with a VAS of 1/10 and subjective improvement in ADLs.

Fluoroscopy



Figure 1 (AP) and Figure 2 (lateral) show pre-contrast final spinal needle placement. Figure 3 (AP) and Figure 4 (lateral) show post-contrast studies.

Discussion

Primary OP presents with anteromedial groin pain provoked with hip flexion, positive single adductor, bilateral adductor, and squeeze tests.[3,4] There may be tenderness of the pubic symphysis and ramus. One case report found clinical and radiologic recovery of OP following pubic symphysis methylprednisolone injection.[5] Male CPP offers diagnostic complexity with a tendency for musculoskeletal etiologies to remain underrecognized. Pain physicians are uniquely positioned to identify missed pain generators through targeted examination and image-guided diagnostic intervention.

Conclusion

While male CPP is not vastly prevalent, evaluation and treatment is costly when pain is refractory and alternative etiologies are overlooked. The pathophysiology and treatment of OP varies, however, there are promising results from case reports regarding use of pubic symphysis steroid injections. Further ethexperimental studies must be done to evaluate presence of superiority which may offer support for a minimally invasive and cost-effective treatment for chronic pelvic pain.

References

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